MDR Tracking Number: M5-04-3532-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 06-16-04.

Dates of service 11-07-03 and 1-15-04 through 4-12-04 were withdrawn by the requestor. All medical fee issues were withdrawn by the requestor.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, therapeutic procedures, and treatment procedures from 9/29/03 through 1/14/04 **were found** to be medically necessary. The office visits, therapeutic procedures, and treatment procedures from 1/15/04 through 4-12-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Requestor has forfeited its right to reimbursement for its failure to file the requisite financial disclosure with the TWCC. Per Texas Administrative Code Rule 180.24 (c) Failure to disclose a financial interest when the health care practitioner had actual knowledge of the financial interest or acted in reckless disregard or deliberate ignorance as to the existence of the financial interest is subject to a penalty of forfeiture of the right to reimbursement for any services rendered on the claim during the period of noncompliance, regardless of whether the circumstances of the services themselves were subject to disclosure and regardless of whether the services were medically necessary.

This Findings and Decision and Order is hereby issued this 17th day of December, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

August 19, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-3532-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: letter of medical necessity, office notes, physical therapy notes, FCE and radiology reports.
Information provided by Respondent: correspondence and designated doctor exams.

Clinical History:
The records indicate the claimant was injured on the job on ___. The records indicate he was treated by the company doctor and requested a change of treating doctors after being unsatisfied with the care he was receiving. In September of 2003, he had to relocate to another town due to a family emergency. Due to the fact that he continued to have problems, he sought care in a new facility on 9/29/03. He had previously received care and treatment for his injury. However, ongoing subjective symptoms, as well as the

nature and extent of his injury clinically, justify his initial evaluation at the new doctor's office on 9/29/03. On 10/3/03, lumbar MRI was performed, which confirmed the patient had a disc injury and not just a strain/sprain complex injury.

The patient was referred to a specialist who indicated an additional 6 weeks of non-operative treatment. He indicated that if the patient had not responded sufficiently after 6 weeks of care, consideration for lumbar injections would be made. On 1/14/04, the patient followed up with the specialist, and the specialist indicated the patient described some right-sided lumbar pain primarily with certain positions of his back such as forward bending. The patient denied any numbness, tingling, or weakness in his lower extremities. The records indicate the patient had been doing a regular exercise program under the care of his treating doctor. Physical examination on this date was normal in that the patient was walking in an upright posture, and his gait was symmetric. He had a negative straight leg raising test in his bilateral lower extremities. He had a negative Lasegue's test of his bilateral lower extremities. His motor and sensory was intact in his lower extremities. The plan at that time was the recommendation that he had previously considered, which was an injection, but due to the fact the patient had responded to the care and radiculopathy was no longer present, the injections were not needed at this time. The specialist recommended the patient return to his doctor if the radicular symptoms return.

Disputed Services:
Office visits, therapeutic procedures and treatment procedures during the period of 09/29/03 through 04/12/04.

Decision:
The reviewer partially agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary from 09/29/03 through 01/14/04. Treatment and services in dispute as stated above were not medically necessary in this case after 01/15/04.

Rationale:
There was sufficient documentation, which includes subjective symptoms and objective findings on the initial examination to warrant additional care and diagnostic testing for this patient's on the job injury. Clinical findings and diagnostic testing confirm the need for additional treatment beyond the normal 4-6 weeks of treatment, which would normally be allowed for a simple strain/sprain complex.

National treatment guidelines allow for this type of treatment for this type of injury. However, they do not allow for the intensity, frequency, and number of visits this patient received for his on the job injury. Once the patient was re-evaluated by his new doctor after his move, a 6-8 week program utilizing minimal passive therapy with rapid progression into active therapy and instruction and graduation to a home exercise program would have been appropriate.

Overriding the facts of the specialist's evaluation on 1/14/04 in which there were no objective findings present which would require additional care, indicates the patient did not need additional in-office care as it relates to this on the job injury after 1/14/04. The records indicate the patient had received several weeks of active therapy and should have been able to progress satisfactorily into a self-directed home exercise program

utilizing information he obtained from his treating doctor's office. In conclusion, all denied services from 9/29/03 through 1/14/04 were, in fact, reasonable, usual, customary, and medically necessary for the treatment of this patient's on the job injury. All treatment rendered after 1/15/04 was not medically necessary treatment for this patient's on the job injury.

Sincerely,